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No. 06-324

In the Supreme Court of the United States

BLUE CROSS & BLUE SHIELD OF MICHIGAN,
Petitioner,

v.

MICHAEL A. GENORD, M.D.; JOHN R. SANBORN, M.D.; PAULA M. FISHBAUGH, M.D.; ANDREA L. SCHILLER, M.D.; MARK D. DYKOWSKI, M.D.; JOHN E. ECKELE, M.D.; BETTY S. CHU, M.D.,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

PETITIONER'S REPLY BRIEF

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PETITIONER'S REPLY TO BRIEF IN OPPOSITION

Respondents' Brief in Opposition falls far short of responding to Petitioner Blue Cross Blue Shield of Michigan's ("BCBSM") articulated bases for why the Court should grant certiorari in this case. The reason is evident – as discussed below, Respondents' brief demonstrates a fundamental misunderstanding of this Court's decision in *United States Department of Treasury v. Fabe*, 508 U.S. 491 (1993), and the manner in which allowing Respondents' RICO claims to proceed would impair Michigan's statutory framework for resolving payment disputes between BCBSM and medical providers.

I. *FABE* MANDATES THE APPLICATION OF THE BROAD PURPOSES OF MICHIGAN'S REGULATION OF THE INSURER-PROVIDER RELATIONSHIP, NOT THE NARROWER ANALYSIS APPLIED IN ERROR BY THE SIXTH CIRCUIT AND NOW URGED BY RESPONDENTS

Respondents misconstrue *Fabe* when they argue that the nature of their claim dictates whether Michigan's comprehensive regulation of provider reimbursement issues is protected from preemption under the McCarran-Ferguson Act, 15 U.S.C. § 1012. To the contrary, as *Fabe* explicitly held, McCarran-Ferguson reverse preemption depends not on the nature of the claim asserted, but rather on whether *the state law at issue* is "'aimed at protecting or regulating th[e] relationship [between insurer and insured, directly or indirectly.'" *Fabe*, 508 U.S. at 501, citing *SEC v. National Securities, Inc.*, 393 U.S. 453, 460 (1969).

Thus, the proper focus of the McCarran-Ferguson analysis is not, as Respondents contend, on the specific conduct being challenged (i.e., BCBSM's alleged failure to properly process Respondents' claims for reimbursement), but rather on the purpose of the state law regulating that conduct and whether it is designed to protect the interests of policyholders. It is Michigan's comprehensive regulation of provider reimbursement issues for the benefit of policyholders that implicates the protections of the McCarran-Ferguson Act and requires the reverse preemption of federal laws such as RICO that do not regulate the business of insurance. This Court in *Fabe* could hardly have made that point more clear, yet it either continues to escape Respondents' attention – or they impermissibly ignore *Fabe*.

Notably, Respondents fail even to address the myriad statutory and regulatory provisions relied on by BCBSM that mandate the use of provider reimbursement arrangements and comprehensively regulate the provider reimbursement relationship. Nor do they dispute that the express statutory purpose for the regulation is to "assure subscribers [the insureds] reasonable access to, and reasonable cost and quality of, health care services." Mich. Comp. Laws § 550.1504(1); *see also* Mich. Comp. Laws § 550.1502a and § 550.53(1) (mandating reimbursement agreements which "control health care costs, assure appropriate utilization of health care services, and maintain quality of health care"). This inextricable link between regulation of provider reimbursement and the protection of policyholders is hardly "tenuous" as Respondents contend. Brief in Opposition at 6, 8.

Incredibly, Respondents further argue that *Fabe* somehow supports the Sixth Circuit's narrow focus on whether the reimbursement arrangements on which Respondents' claim is

based met the criteria set forth in *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119 (1982), for determining whether certain *activities* are exempt from federal antitrust laws. According to Respondents, "this Court expressly relied on *Pireno*." Brief in Opposition at 7. But as the Seventh Circuit explained in *Autry v. Northwest Premium Services, Inc.*, 144 F.3d 1037 (7th Cir. 1998), such a reliance on *Fabe* is misplaced:

> Although the Court distinguished *Pireno* as applying to cases involving the antitrust exemption, it employed a *Pireno* analysis in its discussion. . . . We read the *Fabe* Court's *Pireno* analysis as responding to the petitioner's argument that the appropriate question was whether the liquidation of an insolvent insurance company is part of the "business of insurance." By interpreting the statute as not merely ranking creditor priority in bankruptcy, but as affecting the actual performance of the insurance contract," the Supreme Court established that even under *Pireno* the statute was one "enacted . . . for the purpose of regulating the business of insurance." Thus the Supreme Court defeated the petitioner's argument on its own ground. Understanding the Court's *Pireno* analysis in this context, we conclude that the *Pireno* analysis is not a necessary part of determining whether a statute is "enacted . . . for the purpose of regulating the business of insurance."

144 F.3d at 1044, fn. 5.

Respondents further claim that the Sixth Circuit's decision is "in line with decisions from other circuits," Brief in Opposition at 8, yet they fail to cite even one such decision. Similarly unsupported is their assertion that "federal courts

have recognized that the relationship between medical providers . . . and insurers seldom involve policyholders' interest." Brief in Opposition at 5. Respondents cite exactly one decision in support of their position, a federal district court opinion from Florida: *In re Managed Care Litigation*, 298 F. Supp. 2d 1259 (S.D. Fla. 2003). Rather than providing "guidance" as Respondents suggest, the court's opinion in *In re Managed Care* is even more flawed than the Sixth Circuit's decision in this case, which is surely why the Sixth Circuit did not even cite it. Although the Sixth Circuit refused to recognize the manner in which Michigan's extensive regulation of provider reimbursement issues protects policyholders, it at least made passing note of those provisions. In *In re Managed Care*, the court did not even look at the extent to which the reimbursement arrangements utilized by the insurers in that case were regulated by state law or the manner in which they impacted those insurers' relationships with their policyholders.

Respondents also argue that BCBSM has "manufactured" a conflict between the Sixth Circuit's decision in this case and that of the Fourth Circuit in *American Chiropractic Association v. Trigon Healthcare, Inc.*, 367 F.3d 212 (4th Cir. 2004). That assertion lacks merit and is based upon a complete misreading of *Trigon*. Despite Respondents' claim, *Trigon* did not involve "an insurance company's refusal to cover chiropractic services." Brief in Opposition at 8. Rather, the plaintiff chiropractors' claim in *Trigon* was that the insurance company had conspired to shift that business away from them to medical doctors. As the *Trigon* court explained:

> American Chiropractic filed this eight count complaint alleging violations of federal antitrust laws, the Racketeer Influenced and Corrupt Organizations Act

> (RICO), and various state laws, claiming that Trigon and the medical doctors and associations were engaged in a conspiracy that used Trigon's reimbursement policies and treatment guidelines to limit severely the flow of insurance dollars to chiropractors and steer those monies toward medical doctors.

Id. at 217-218.

Consequently, the dispute between the medical providers and insurer in *Trigon* was of no material difference from the dispute between Respondents and BCBSM in this case. Yet the *Trigon* court, as mandated by *Fabe*, applied the first clause of § 2(b) of the McCarran-Ferguson Act broadly and concluded that the Virginia law regulating the insurer's reimbursement arrangements was a law enacted for the purpose of regulating the business of insurance. *Id.* at 231.

Respondents also seek to downplay the broader conflict existing among the circuits as to the McCarran-Ferguson analysis required under *Fabe* by asserting that none of the decisions cited by BCBSM "involve an insurer's relationship with its providers." Brief in Opposition at 9. Such an assertion misses the point entirely. The conflict among the circuits should be of concern to the Court not because those decisions are factually similar to this one (they of course are not), but because they demonstrate substantial confusion and disagreement over *Fabe*'s instruction that the analysis under the first clause of § 2(b) of the McCarran-Ferguson Act should broadly focus on whether the purpose of the state law is to protect policyholders. That is an issue that transcends this case and demonstrates both its jurisprudential significance and the need for this Court's guidance.

II. BECAUSE MICHIGAN'S STATUTORY HEALTH INSURANCE SCHEME DOES NOT AFFORD A PRIVATE RIGHT OF ACTION TO MEDICAL PROVIDERS AND INSTEAD LIMITS THEM TO ADMINISTRATIVE REMEDIES, RICO CLAIMS WOULD IMPERMISSIBLY INVALIDATE, IMPAIR OR SUPERSEDE THE HEALTH INSURANCE SCHEME

Finally, Respondents argue that the Court should decline to grant certiorari because application of RICO would not "invalidate, impair or supersede" Michigan's comprehensive regulation of provider reimbursement issues even if the Court agreed that the McCarran-Ferguson Act otherwise applied here. Brief in Opposition at 12. Neither the district court nor the Sixth Circuit reached the impairment issue.

As with the rest of Respondents' arguments, this one is equally long on rhetoric and short on substance. Respondents claim that this Court's decision in *Humana, Inc. v. Forsyth*, 525 U.S. 299 (1999) "put to rest" the issue whether allowing their RICO claim to proceed would impermissibly impair the statutory and regulatory provisions enacted in Michigan for resolving reimbursement disputes. That is a baseless assertion founded on the faulty premise that "[b]oth Nevada and Michigan allow a private right of action for fraud." Brief in Opposition at 11. What Respondents fail to mention is that only *policyholders* have a right to pursue such claims against BCBSM – the physicians do not under Michigan law. In *P.T. Today, Inc. v. Comm'r of the Office of Financial & Insurance Services*, 270 Mich. App. 110, 148-149, 715 N.W.2d 398 (2006), the Michigan Court of Appeals confirmed that *medical providers have no private right of action under the statutory provisions cited by Respondents* and, moreover, that *they cannot bring tort claims premised upon matters governed*

by those provisions. This is flatly contrary to Respondents' assertion that they have a right to bring a fraud claim against BCBSM relating to reimbursement disputes.

Michigan law instead requires medical providers to file a claim with the Insurance Commissioner. *See* Mich. Comp. Laws § 550.1404. The Insurance Commissioner's regulations specifically set forth the procedure by which a "person who believes that a health care corporation has wrongfully refused his or her claim" can challenge that decision. Mich. Admin. Code R. 550.102(1). A "claim," in turn, is expressly defined as including a "request for payment by a provider under his or her agreement with a health care corporation." Mich. Admin. Code R. 550.101(a). If BCBSM is found to have improperly denied a claim for payment (which is the very essence of Respondents' claim in this case), it must be paid within 30 days of the Insurance Commissioner's decision, plus 12% interest. Mich. Admin. Code R. 550.108.

There can be no doubt that this regulatory framework for resolving payment disputes would be impaired if RICO claims like those alleged by Respondents' were allowed to proceed. Indeed, the Eighth Circuit, in a case decided three months after *Humana* and relying on *Humana*, barred a RICO-based class action under the McCarran-Ferguson Act because Minnesota, like Michigan, had "enacted a comprehensive statutory scheme to regulate the business of insurance." *LaBarre v. Credit Acceptance Corp.*, 175 F.3d 640, 643 (8th Cir. 1999). The Eighth Circuit observed that "Minnesota law permits only administrative recourse . . . and, unlike RICO, does not provide a private cause of action . . . ." *Id.* The court further noted that its holding was consistent with *Humana*:

> [W]e held in [*Doe v. Norwest Bank Minnesota*, 107 F.3d 1297 (8th Cir. 1997)] that the McCarran-Ferguson Act barred the application of RICO to an insurer which allegedly violated [a state insurance statute] because "the extraordinary remedies of RICO would frustrate, and perhaps even supplant, Minnesota's carefully developed scheme of regulation." *Doe*, 107 F.3d at 1308. The Supreme Court applied [a] similar analysis in *Humana* and stated the McCarran-Ferguson Act precludes the application of RICO when RICO directly conflicts with a state's insurance statutes, frustrates any declared state policy, or interferes with a state's administrative regime.

As *LaBarre* properly recognized, and contrary to Respondents' assertions, *Humana* is not dispositive where as here, among various reasons, a party's sole recourse for alleged conduct regulated under a state's insurance laws is an administrative remedy. Because Michigan law does not authorize a private cause of action by providers and provides solely for an administrative remedy,[1] the application of RICO would "invalidate, impair, or supersede" Michigan's comprehensive statutory health insurance scheme regulating, among other things, reimbursement disputes between BCBSM and medical providers.

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[1] Although Respondents have also alleged a breach of contract claim, a breach of contract allegation cannot form the basis for a RICO claim. *See, e.g., Frank v. D'Ambrosi*, 4 F.3d 1378, 1385 (6th Cir. 1993).

CONCLUSION

For all of the reasons set forth above and in its petition, BCBSM respectfully requests that this Court grant its petition for a writ of certiorari.

Respectfully Submitted

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